STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E210	A. BUILDING _____ B. WING _____	C 03/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW MANOR OF PEABODY	**500 PEABODY PEABODY, KS 66866**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of the Complaint Investigation #63991 and a partial extended survey. A revised copy of the deficiencies was sent to the provider on 3/19/13.	F 000		
F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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This REQUIREMENT is not met as evidenced by:
The facility had a census of 50 residents. The sample included 4 residents. Based on record review and interview the facility failed to adequately assess elevated temperatures, changes in condition and respiratory distress and notify the physician for 2 sampled residents. (#1 and #2)

Findings included:

- Review of the 01/22/13 Physician's Progress Note for Resident #2 indicated his/her lungs were clear and the resident had no respiratory distress or health concerns.

Resident #2's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 02/04/13, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 7 (severe impairment) with physical and verbal behaviors and inattention. The MDS also indicated the resident was independent with eating, transfers, ambulation, dressing, toileting and personal hygiene. The MDS further indicated the resident received no oxygen therapy and had no shortness of breath or trouble breathing.

The 02/11/13 care plan directed the staff to report changes in the resident's health status to the physician as needed. The care plan also directed the staff to administer medications to the resident as ordered by the physician.

The 02/13/13 at 11:20 PM, nurse's note indicated

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the staff noted the resident was stumbling around his/her room. The nurse's note also indicated the resident had an elevated temperature of 100.8 degrees and received 2 tablets of Tylenol 325 (mg) miligrams (per the physician's order, initiated on 09/16/03, to administer every 4 hours as needed for pain and/or elevated temperature).

The 02/14/13 at 4:30 PM, nurse's note indicated the resident had an elevated temperature of 102.2 degrees and received 2 tablets of Tylenol 325 mg. Review of the resident's medical record revealed no documentation the staff assessed the effectiveness of the medication.

The 02/14/13 at 10:25 PM, nurse's note indicated the resident had a dry, nonproductive cough.

The 02/15/13 at 5:00 AM nurse's note indicated the resident had laid on the floor 2 times this shift and required two staff assistance to transfer from the floor.

The 02/15/13 at 6:00 AM, nurse's note indicated the resident had an elevated temperature of 102.6 degrees and received 2 tablets of Tylenol 325 mg (14 hours after the last dose of Tylenol 650 mg for fever).

The 02/15/13 at 1:00 PM, nurse's note indicated the resident was lethargic and weak and the staff had to assist the resident with sitting up and "fed the resident" (resident usually independent with transfers, positioning and eating). The nurse's note also indicated the resident had a loose stool and an elevated temperature of 103.1 degrees (7 hours after the last temperature check and dose of fever medication).

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F 157	Continued From page 3 The 02/15/13 at 1:15 PM, nurse's note indicated the resident had a dry, nonproductive cough and received 2 tablets of Tylenol 325 mg. The 02/15/13 at 2:15 PM, nurse's note indicated the resident was confused, refused to stay in bed and kept stumbling around his/her room. The nurse's note also indicated the resident had pulse a 116 of (elevated - normal pulse 60 to 80), respirations 20 and temperature 104.1 degrees. The 02/15/13 at 3:15 PM, nurse's note indicated the nurse witnessed the resident stumble backwards, fall and hit his/her head. The nurse's notes indicated the resident's neurological assessment was within normal limits and the resident had a blood pressure 120/78, pulse 122, respirations 22 and temperature 103.8 degrees. The 02/15/13 at 5:00 PM, neurological assessment indicated the resident had a blood pressure 140/78, pulse 112, respirations 22 and temperature 103.6 degrees (4 hours after last dose of Tylenol 650 mg for fever). Review of the resident's medical record revealed no documentation the staff administered the 2 tablets of Tylenol 325 mg for the resident's elevated temperature. The 02/15/13 at 10:00 PM, nurse's note indicated the resident had an elevated temperature of 104.1 degrees (9 hours after last dose of Tylenol 650 mg for fever). Review of the resident's medical record revealed no documentation the staff administered the 2 tablets of Tylenol 325 mg for the resident's elevated temperature.	F 157		

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The 02/16/13 at 6:10 AM, nurse's note indicated the resident needed assistance to sit up in bed and was unable to ambulate safely. The nurse's note indicated the resident had a blood pressure 102/70, pulse 96, respirations 28 (elevated - normal respirations 16 to 20 per minute), temperature 103.3 degrees (17 hours after last dose of Tylenol 650 mg for fever). The nurse's note indicated the staff administered 2 tablets of Tylenol 325 mg to the resident.

The Neurological Assessment Flow Sheet indicated the staff assessed the resident for the following elevated respirations:
02/15/13 at 6:00 PM - 26 respirations
02/15/13 at 10:00 PM - 26 respirations
02/16/13 at 2:00 AM - 24 respirations
02/16/13 at 6:00 AM - 28 respirations
02/16/13 at 10:00 AM - 34 respirations

Review of the resident's medical record revealed no documentation the staff assessed the resident's lungs sounds and/or oxygen levels during the 16 hours the resident had elevated respirations.

The 02/16/13 at 7:45 AM, nurse's note indicated the facility received a physician's order to administer 75 mg of Tamiflu (anti-influenza medication) twice a day for 5 days to the resident (3 days after the staff had assessed the resident for influenza symptoms).

Review of the resident's medical record lacked any documentation from 02/13/13 to 02/16/13, the facility notified the physician regarding the resident's change in condition.

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The 02/16/13 at 12:45 PM, nurse's notes indicated the resident was unresponsive, had rhonchi (coarse, abnormal lung sounds) in both lungs and oxygen levels were 76 percent (oxygen levels below 88 percent indicate respiratory distress).

On 02/16/13 at 12:50 PM, nurse's notes indicated the staff called 911 and notified the emergency room and the physician.

On 02/16/13 at 1:18 PM, Emergency Department Nursing Assessment indicated the resident was unresponsive and had an elevated temperature of 104.0. The assessment also indicated the resident had rapid, labored respirations with use of accessory muscles and crackles (coarse, abnormal sounds) in both lungs. The assessment further indicated the resident had a diagnosis of Acute Respiratory Failure requiring Intubation (insertion of a tube to maintain an open airway).

The 02/17/13 at 12:15 AM, nurse's note indicated the resident had died at the hospital.

On 03/12/13 at 3:41 PM, Nurse B stated the staff should closely monitor and assess changes in the resident's condition such as elevated temperatures and respiratory distress. Nurse B also stated the staff should notify the physician to ensure the resident recieved the appropriate cares and treatments.

On 03/13/13 at 8:11 AM, Nurse C stated the staff should frequently assess and record the resident's elevated temperatures and respiratory distress. Nurse C also stated medications for elevated temperatures should be administered as

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ordered by the physician. Nurse C further stated the staff should provide comprehensive assessments and notify the physician when the resident had elevated temperatures and/or respiratory distress.

On 03/13/13 at 9:44 AM, Nurse D stated the facility had no standing orders or policies to direct the staff to notify the physician when a resident had changes in condition. Nurse D also stated the staff should administer medications as physician ordered to control elevated temperatures. Nurse D further stated the staff should provide comprehensive assessments when the resident had changes in condition and notify the physician.

The facility's failure to notify the physician of elevated temperatures, changes in condition and respiratory distress for Resident #2 caused the resident harm due to an unnecessary delay for the resident to recieve treatment.

- Resident #1's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 02/13/13, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 15 (cognitively intact). The MDS also indicated the resident was independent with transfers, ambulation, toileting and personal hygiene. The MDS further indicated the resident received no oxygen therapy and had no shortness of breath or trouble breathing.

The 02/18/13 care plan directed the staff to report changes in the resident's health status to the physician as needed. The care plan also directed the staff to administer medications to the resident as ordered by the physician.

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The 02/20/13 at 4:45 PM, nurse's note indicated the resident had a temperature of 100.8 degrees and received 2 tablets of Tylenol 500 (mg) milligrams (per the 12/19/11 physician's order to administer every 4 hours as needed for pain and/or elevated temperature).

The 02/20/13 at 10:25 PM, nurse's note indicated the resident had a temperature of 103.5 degrees and received 2 tablets of Tylenol 500 mg for elevated temperature.

The 02/20/13 at 6:30 AM, nurse's note indicated the resident's voice was hoarse and the resident had a sore throat.

The 02/21/13 at 1:25 PM, nurse's note indicated the resident had a temperature of 103.5 degrees and received 2 tablets of Tylenol 500 mg (15 hours after the last temperature check and dose of fever medication).

The 02/21/13 at 2:20 PM, nurse's note indicated the facility notified the physician and received an order to administer Tamiflu (anti-influenza medication) 75 mg, twice a day, for 5 days to the resident.

The 02/21/13 at 8:40 PM, nurse's note indicated the resident had an elevated temperature of 103.9 degrees and received 2 tablets of Tylenol 500 mg (7 hours after the last temperature check and dose of fever medication).

The 02/22/13 at 3:30 AM, nurse's note indicated the resident had an elevated temperature of 101.5 degrees and received 2 tablets of Tylenol 500 mg (7 hours after the last temperature check

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and dose of fever medication).

The 02/22/13 at 1:00 PM, nurse's note indicated the staff assisted the resident to the bathroom due to his/her weakness.

The 02/22/13 at 2:40 PM, nurse's note indicated the resident had an elevated temperature of 102.8 degrees and received 2 tablets of Tylenol 500 mg (11 hours after the last temperature check and dose of fever medication).

Review of the resident's medical record revealed the following blood pressures:
01/04/13 - 118/72
01/11/13 - 110/70
01/18/13 - 122/78
01/25/13 - 118/60
02/01/13 - 110/70
02/08/13 - 118/74
02/15/13 - 112/80
02/22/13 at 6:20 AM - 90/50 (normal 120/80)
02/22/13 at 2:40 PM - 94/54
02/22/13 at 9: 45 PM - 90/58

Review of the resident's medical record revealed no documentation the staff had assessed the resident for signs of dehydration related to his/her sudden hypotension (low blood pressure) and/or notified the physician regarding the resident's change in condition.

The 02/22/13 at 9:45 PM, nurse's note indicated the resident had an elevated temperature of 102.7 degrees and received 2 tablets of Tylenol 500 mg (7 hours after the last temperature check and dose of fever medication). The nurse's note

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also indicated the resident had an oxygen level of 81 percent (oxygen levels below 88 percent indicate respiratory distress). The nurse' s note indicated the staff provided oxygen to the resident at 3 liters/minute per a nasal cannula.

Review of the resident's medical record revealed no documentation the staff assessed the resident's lung sounds.

The 02/23/13 at 6:30 AM, nurse's note indicated the resident continued to receive oxygen at 3 liters/minute. The nurse's note also indicated the resident complained of his/her upper chest muscles hurting. Continued review of the nurse's note revealed no documentation the staff further assessed the resident's lung sounds, although the resident had discomfort.

The 02/23/13 at 3:40 PM, nurse's note indicated the resident's oxygen level was 91 percent on 3 liter/minute oxygen Continued review of the nurse's note revealed no documentation the staff further assessed the resident's lung sounds, although previously the resident had complained of his/her upper chest muscles hurting.

The 02/23/13 at 10:00 PM, nurse's note indicated the resident was confused and had an oxygen level of 90 percent on 3 liter/minute. Continued review of the nurse's note revealed no documentation the staff further assessed the resident's lung sounds.

The 02/24/13 at 6:35 AM, nurse's note indicated the staff found the resident deceased in his/her room.

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Review of the resident's medical record revealed the resident had received oxygen therapy due to respiratory distress for 48 hours. Continued review of the resident's medical record revealed no documentation the staff had assessed the resident's lung sounds or notified the physician of the resident's respiratory distress.

On 03/12/13 at 3:41 PM, Nurse B stated the staff should closely monitor and assess changes in the resident's condition such as elevated temperatures and respiratory distress. Nurse B also stated the staff should notify the physician to ensure the resident recieved the appropriate cares and treatments.

On 03/13/13 at 8:11 AM, Nurse C stated the staff should frequently assess and record the resident's elevated temperatures and respiratory distress. Nurse C also stated medications for elevated temperatures should be administered as ordered by the physician. Nurse C further stated the staff should provide comprehensive assessments and notify the physician when the resident had elevated temperatures and/or respiratory distress.

On 03/13/13 at 9:44 AM, Nurse D stated the facility had no standing orders or policies to direct the staff to notify the physician when a resident had changes in condition. Nurse D also stated the staff should administer medications as physician ordered to control elevated temperatures. Nurse D further stated the staff should provide comprehensive assessments when the resident had changes in condition and notify the physician.

The facility's failure to notify the physician of

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F 157	Continued From page 11 elevated temperatures, changes in condition and respiratory distress for Resident #1 caused the resident harm due to an unnecessary delay for the resident to recieve treatment.	F 157		
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility had a census of 50 residents. The sample included 4 residents. Based on record review and interview the facility failed to adequately monitor elevated temperatures, provide fever medication as ordered by the physician, accurately and thoroughly assess respiratory status and notify the physician for 2 sampled residents (#1 and #2), who had significant respiratory distress and decline in physical health. This failure placed the resident in immediate jeopardy. Findings included: - Review of the 01/22/13 Physician's Progress Note for Resident #2 indicated his/her lungs were clear and the resident had no respiratory distress or health concerns. Resident #2's quarterly (MDS) Minimum Data Set	F 309		

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3.0 assessment, dated 02/04/13, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 7 (severe impairment) with physical and verbal behaviors and inattention. The MDS also indicated the resident was independent with eating, transfers, ambulation, dressing, toileting and personal hygiene. The MDS further indicated the resident received no oxygen therapy and had no shortness of breath or trouble breathing.

The 02/11/13 care plan directed the staff to report changes in the resident's health status to the physician as needed. The care plan also directed the staff to administer medications to the resident as ordered by the physician.

The 02/13/13 at 11:20 PM, nurse's note indicated the staff noted the resident was stumbling around his/her room. The nurse's note also indicated the resident had an elevated temperature of 100.8 degrees and received 2 tablets of Tylenol 325 (mg) milligrams (per the physician's order, indicated on 09/16/03, to administer every 4 hours as needed for pain and/or elevated temperature).

The 02/14/13 at 4:30 PM, nurse's note indicated the resident had an elevated temperature of 102.2 degrees and received 2 tablets of Tylenol 325 mg. Review of the resident's medical record revealed no documentation the staff assessed the effectiveness of the medication.

The 02/14/13 at 10:25 PM, nurse's note indicated the resident had a dry, nonproductive cough.

The 02/15/13 at 5:00 AM nurse's note indicated

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the resident had laid on the floor 2 times this shift and required two staff assistance to transfer from the floor.

The 02/15/13 at 6:00 AM, nurse's note indicated the resident had an elevated temperature of 102.6 degrees and received 2 tablets of Tylenol 325 mg (14 hours after the last dose of Tylenol 650 mg for fever).

The 02/15/13 at 1:00 PM, nurse's note indicated the resident was lethargic and weak and the staff had to assist the resident with sitting up and "fed the resident" (resident usually independent with transfers, positioning and eating). The nurse's note also indicated the resident had a loose stool and an elevated temperature of 103.1 degrees (7 hours after the last temperature check and dose of fever medication).

The 02/15/13 at 1:15 PM, nurse's note indicated the resident had a dry, nonproductive cough and received 2 tablets of Tylenol 325 mg.

The 02/15/13 at 2:15 PM, nurse's note indicated the resident was confused, refused to stay in bed and kept stumbling around his/her room. The nurse's note also indicated the resident had pulse 116 (elevated - normal pulse 60 to 80), respirations 20 and temperature 104.1 degrees.

The 02/15/13 at 3:15 PM, nurse's note indicated the nurse witnessed the resident stumble backwards, fall and hit his/her head. The nurse's notes indicated the resident's neurological assessment was within normal limits and the resident had a blood pressure 120/78, pulse 122, respirations 22 and temperature 103.8 degrees.

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The 02/15/13 at 5:00 PM, neurological assessment indicated the resident had a blood pressure 140/78, pulse 112, respirations 22 and temperature 103.6 degrees (4 hours after last dose of Tylenol 650 mg for fever). Review of the resident's medical record revealed no documentation the staff administered the 2 tablets of Tylenol 325 mg for the resident's elevated temperature.

The 02/15/13 at 10:00 PM, nurse's note indicated the resident had an elevated temperature of 104.1 degrees (9 hours after last dose of Tylenol 650 mg for fever). Review of the resident's medical record revealed no documentation the staff administered the 2 tablets of Tylenol 325 mg for the resident's elevated temperature.

The 02/16/13 at 6:10 AM, nurse's note indicated the resident needed assistance to sit up in bed and was unable to ambulate safely. The nurse's note indicated the resident had a blood pressure 102/70, pulse 96, respirations 28 (elevated - normal respirations 16 to 20 per minute), temperature 103.3 degrees (17 hours after last dose of Tylenol 650 mg for fever). The nurse's note indicated the staff administered 2 tablets of Tylenol 325 mg to the resident.

The Neurological Assessment Flow Sheet indicated the staff assessed the resident for the following elevated respirations:
02/15/13 at 6:00 PM - 26 respirations
02/15/13 at 10:00 PM - 26 respirations
02/16/13 at 2:00 AM - 24 respirations
02/16/13 at 6:00 AM - 28 respirations
02/16/13 at 10:00 AM - 34 respirations

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Review of the resident's medical record revealed no documentation the staff assessed the resident's lungs sounds and/or oxygen levels during the 16 hours the resident had elevated respirations.

The 02/16/13 at 7:45 AM, nurse's note indicated the facility received a physician's order to administer 75 mg of Tamiflu (anti-influenza medication) twice a day for 5 days to the resident (3 days after the staff had assessed the resident for influenza symptoms).

Review of the resident's medical record lacked any documentation from 02/13/13 to 02/16/13, the facility notified the physician regarding the resident's change in condition.

The 02/16/13 at 12:45 PM, nurse's notes indicated the resident was unresponsive, had rhonchi (coarse, abnormal lung sounds) in both lungs and oxygen levels were 76 percent (oxygen levels below 88 percent indicate respiratory distress).

On 02/16/13 at 12:50 PM, nurse's notes indicated the staff called 911 and notified the emergency room and the physician.

On 02/16/13 at 1:18 PM, Emergency Department Nursing Assessment indicated the resident was unresponsive and had an elevated temperature of 104.0. The assessment also indicated the resident had rapid, labored respirations with use of accessory muscles and crackles (coarse, abnormal sounds) in both lungs. The assessment further indicated the resident had a diagnosis of

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Acute Respiratory Failure requiring Intubation (insertion of a tube to maintain an open airway).

The 02/17/13 at 12:15 AM, nurse's note indicated the resident had died at the hospital.

On 03/12/13 at 3:41 PM, Nurse B stated the staff should closely monitor and assess changes in the resident's condition such as elevated temperatures and respiratory distress. Nurse B also stated the staff should notify the physician to ensure the resident received the appropriate cares and treatments.

On 03/13/13 at 8:11 AM, Nurse C stated the staff should frequently assess and record the resident's elevated temperatures and respiratory distress. Nurse C also stated medications for elevated temperatures should be administered as ordered by the physician. Nurse C further stated the staff should provide comprehensive assessments and notify the physician when the resident had elevated temperatures and/or respiratory distress.

On 03/13/13 at 9:44 AM, Nurse D stated the facility had no standing orders or policies to direct the staff to notify the physician when a resident had changes in condition. Nurse D also stated the staff should administer medications as physician ordered to control elevated temperatures. Nurse D further stated the staff should provide comprehensive assessments when the resident had changes in condition and notify the physician.

The facility failed to adequately monitor elevated temperatures, provide fever medication as ordered by the physician and accurately assess

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the respiratory status for Resident #2., who had significant respiratory distress and decline in physical health.

- Resident #1's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 02/13/13, indicated the resident had a (BIMS) Brief Interview for Mental Status score of 15 (cognitively intact). The MDS also indicated the resident was independent with transfers, ambulation, toileting and personal hygiene. The MDS further indicated the resident received no oxygen therapy and had no shortness of breath or trouble breathing.

The 02/18/13 care plan directed the staff to report changes in the resident's health status to the physician as needed. The care plan also directed the staff to administer medications to the resident as ordered by the physician.

The 02/20/13 at 4:45 PM, nurse's note indicated the resident had a temperature of 100.8 degrees and received 2 tablets of Tylenol 500 (mg) milligrams (per the 12/19/11 physician's order to administer every 4 hours as needed for pain and/or elevated temperature).

The 02/20/13 at 10:25 PM, nurse's note indicated the resident had a temperature of 103.5 degrees and received 2 tablets of Tylenol 500 mg for elevated temperature.

The 02/20/13 at 6:30 AM, nurse's note indicated the resident's voice was hoarse and the resident had a sore throat.

The 02/21/13 at 1:25 PM, nurse's note indicated the resident had a temperature of 103.5 degrees

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and received 2 tablets of Tylenol 500 mg (15 hours after the last temperature check and dose of fever medication).

The 02/21/13 at 2:20 PM, nurse's note indicated the facility notified the physician and received an order to administer Tamiflu (anti-influenza medication) 75 mg, twice a day, for 5 days to the resident.

The 02/21/13 at 8:40 PM, nurse's note indicated the resident had an elevated temperature of 103.9 degrees and received 2 tablets of Tylenol 500 mg (7 hours after the last temperature check and dose of fever medication).

The 02/22/13 at 3:30 AM, nurse's note indicated the resident had an elevated temperature of 101.5 degrees and received 2 tablets of Tylenol 500 mg (7 hours after the last temperature check and dose of fever medication).

The 02/22/13 at 1:00 PM, nurse's note indicated the staff assisted the resident to the bathroom due to his/her weakness.

The 02/22/13 at 2:40 PM, nurse's note indicated the resident had an elevated temperature of 102.8 degrees and received 2 tablets of Tylenol 500 mg (11 hours after the last temperature check and dose of fever medication).

Review of the resident's medical record revealed the following blood pressures:
01/04/13 - 118/72
01/11/13 - 110/70
01/18/13 - 122/78
01/25/13 - 118/60

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F 309	Continued From page 19 02/01/13 - 110/70 02/08/13 - 118/74 02/15/13 - 112/80 02/22/13 at 6:20 AM - 90/50 (normal 120/80) 02/22/13 at 2:40 PM - 94/54 02/22/13 at 9: 45 PM - 90/58 Review of the resident's medical record revealed no documentation the staff had assessed the resident for signs of dehydration related to his/her sudden hypotension (low blood pressure) and/or notified the physician regarding the resident's change in condition. The 02/22/13 at 9:45 PM, nurse's note indicated the resident had an elevated temperature of 102.7 degrees and received 2 tablets of Tylenol 500 mg (7 hours after the last temperature check and dose of fever medication). The nurse's note also indicated the resident had an oxygen level of 81 percent (oxygen levels below 88 percent indicate respiratory distress). The nurse' s note indicated the staff provided oxygen to the resident at 3 liters/minute per a nasal cannula. Review of the resident's medical record revealed no documentation the staff assessed the resident's lung sounds. The 02/23/13 at 6:30 AM, nurse's note indicated the resident continued to receive oxygen at 3 liters/minute. The nurse's note also indicated the resident complained of his/her upper chest muscles hurting. Continued review of the nurse's note revealed no documentation the staff further assessed the resident's lung sounds, although the resident had discomfort.	F 309		

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The 02/23/13 at 3:40 PM, nurse's note indicated the resident's oxygen level was 91 percent on 3 liter/minute oxygen Continued review of the nurse's note revealed no documentation the staff further assessed the resident's lung sounds, although previously the resident had complained of his/her upper chest muscles hurting.

The 02/23/13 at 10:00 PM, nurse's note indicated the resident was confused and had an oxygen level of 90 percent on 3 liter/minute. Continued review of the nurse's note revealed no documentation the staff further assessed the resident's lung sounds.

The 02/24/13 at 6:35 AM, nurse's note indicated the staff found the resident deceased in his/her room.

Review of the resident's medical record revealed the resident had received oxygen therapy due to respiratory distress for 48 hours. Continued review of the resident's medical record revealed no documentation the staff had assessed the resident's lung sounds or notified the physician of the resident's respiratory distress.

On 03/12/13 at 3:41 PM, Nurse B stated the staff should closely monitor and assess changes in the resident's condition such as elevated temperatures and respiratory distress. Nurse B also stated the staff should notify the physician to ensure the resident received the appropriate cares and treatments.

On 03/13/13 at 8:11 AM, Nurse C stated the staff should frequently assess and record the

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resident's elevated temperatures and respiratory distress. Nurse C also stated medications for elevated temperatures should be administered as ordered by the physician. Nurse C further stated the staff should provide comprehensive assessments and notify the physician when the resident had elevated temperatures and/or respiratory distress.

On 03/13/13 at 9:44 AM, Nurse D stated the facility had no standing orders or policies to direct the staff to notify the physician when a resident had changes in condition. Nurse D also stated the staff should administer medications as physician ordered to control elevated temperatures. Nurse D further stated the staff should provide comprehensive assessments when the resident had changes in condition and notify the physician.

The facility failed to adequately monitor, thoroughly assess, provide consistent interventions and to promptly obtain medical intervention for Resident #1, who had significant respiratory distress without physician notification.

The facility's failure to adequately monitor, thoroughly assess, provide consistent interventions and to promptly obtain medical intervention placed Resident #1 and #2 in immediate jeopardy.

The immediate jeopardy was abated on March 18, 2013, when the facility implemented policy and procedures for Acute Change in condition (ACOC); assessing and identifying its nature, severity and cause (s); physician and responsible party notification; monitoring the resident's response to the treatment implemented for

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F 309	Continued From page 22 ACOC; documentation of assessment findings, actions taken and resident response to the treatments implemented including the effectiveness of as needed medications. The facility implemented the CMS (Center for Medicare and Medicaid Services) INTERACT SBAR Communication Form and Progress Note, INTERACT Care Paths, (dehydration, fever, change in mental status, symptoms of lower respiratory infections and symptoms of UTIs (urinary tract infections) and "when to notify the physician", will be posted at each nurses station. a "hot rack" sticker will be implemented for residents who are to be monitored each shift. The facility Director of Nursing and Medical Director have established parameters for physician notifications which will be posted at each nursing station. The facility completed implementation of the new policies and procedures and inservice of the staff on March 18, 2013. The deficient practice remains at a scope and severity of a G.	F 309		